Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074046	A. BUILDING: ____ B. WING ____	R-C 12/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA CARE ONE ASSISTED LIVING	**2060 WEST FIFTH STREET GREENVILLE, NC 27835**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 000}	Initial Comments The Adult Care Licensure Section conducted a Follow Up Survey and Complaint Investigation on 12/14/23 to 12/15/23.	{D 000}		
{D 273}	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: FOLLOW-UP TO A TYPE B VIOLATION. The Type B Violation was not abated. Based on observations, interviews and record reviews, the facility failed to ensure the primary care provider was notified for 1 of 5 sampled residents (#4) who exhibited a change in behavior including agitation, reported feeling threatened by others and was in possession of a sharp metal object. The findings are: Review of Resident #4's current FL-2 dated 07/11/23 revealed: -Diagnoses included schizoaffective disorder -The resident was intermittently disoriented. -The resident was ambulatory. Review of Resident #4's current care plan dated 07/11/23 revealed: -The resident was independent with ambulation and transfers. -The resident was receiving mental health services. -The resident was receiving medications for	{D 273}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074046	A. BUILDING: ______ B. WING ______	R-C 12/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA CARE ONE ASSISTED LIVING	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 273}	Continued From page 1	{D 273}		

mental illness/behavior.

Review of Resident #4's Facility Care Notes revealed:
-On 10/02/23 at 6:00pm, a medication aide (MA) documented another resident reported that Resident #4 had a "long knife".
-The MA, the Resident Care Coordinator (RCC) on duty and a personal care aide (PCA) "went out back and it hit the ground and it was not a knife it was a blade" and the resident stated that "somebody was going to beat her up."
-The RCC removed the object from Resident #4 and initiated 15-minute checks.
-On 10/03/23 at 11:40am, Resident #4 was involved in an altercation with another resident in the facility's smoking area.
-Resident #4 was sent to the emergency department related to bleeding from her elbow and complaints of back pain.

Review of Resident #4's hospital discharge summary dated 10/05/23 revealed the resident was diagnosed and treated for a left rib fracture.

Interview with Resident #4 on 12/14/23 at 5:15pm revealed:
-She did not ever have a knife at the facility.
-She did not take apart any furniture to make a weapon.
-On 10/02/23, everything was fine with her and the other residents and she did not feel threatened.
-On 10/03/23, in the morning, she was seated outside in the smoking area when another resident told her to get out of her seat and the other resident pushed and hit her and she fell against something, and she had to go to the hospital because her rib was broken.
-She experienced pain in her back everyday from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074046	A. BUILDING: ______ B. WING ______	R-C **12/15/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA CARE ONE ASSISTED LIVING	**2060 WEST FIFTH STREET** **GREENVILLE, NC 27835**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 273}	Continued From page 2	{D 273}		

the rib fracture.

Interview with the MA on 12/14/23 at 3:00pm revealed:
-She was present when another resident reported Resident #4 was in the smoking area and had a knife on 10/02/23.
-She and the RCC investigated and the RCC removed what she thought was a small knife.
-Resident #4 stated she felt threatened by other residents.
-Resident #4 was placed on 15-minute checks.
-She thought she completed an incident report and placed it under the Administrator's office door.
-She could not recall if she had notified Resident #4's Primary Care Provider (PCP) or mental health provider on 10/02/23.

Interview with an RCC on 12/15/23 at 9:12am revealed:
-She was present when another resident reported Resident #4 was in the smoking area and had a knife on 10/02/23.
-Resident #4 did not have a knife but the resident had taken apart her dresser and had detached a metal rail from the dresser drawer's slider.
-She removed the metal object from the resident and the resident was placed on 15-minute checks.
-She notified the facility's Administrator and the RCC who was normally assigned to Resident #4's unit about the incident by phone on 10/02/23.
-She could not recall if she had notified Resident #4's PCP or mental health provider on 10/02/23 but she knew the PCP was scheduled to be in the facility the next day and the PCP was notified on 10/03/23.
-Resident #4 had no further behaviors on 10/02/23.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074046	A. BUILDING: ______ B. WING ______	R-C 12/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA CARE ONE ASSISTED LIVING	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 273}	Continued From page 3	{D 273}		

Interview with the Administrator and the Assistant Regional Director on 12/14/23 at 3:48pm revealed:
-She investigated the report of Resident #4 having a knife that occurred on 10/02/23 and determined Resident #4 did not have a knife but the resident had been experiencing an increase in agitation and had been tearing apart her room and took apart her dresser and removed the metal drawer slider from the dresser.
-The metal drawer slider was determined to be the object that was reported by another resident as a knife on 10/02/23.
-She was not able to locate any documentation of the investigation she had completed.

Interview with Resident #4's PCP on 12/14/23 at 4:50pm revealed:
-She was not aware Resident #4 had an increase in agitation, felt threatened by others or was reported to have a knife or metal object on 10/02/23.
-She was aware of the physical altercation that occurred on 10/03/23.
-She expected the facility to notify her of changes in residents' status or if a resident was feeling unsafe.
-If she had been notified of the change in Resident #4's behaviors on 10/02/23 she would have been able to obtain more information to evaluate the situation and make recommendations for the resident's safety.

Interview with Resident #4's mental health provider on 12/15/23 at 8:48am revealed:
-She was not aware of the incident on 10/02/23.
-She was made aware of the altercation that occurred on 10/03/23.
-She expected the facility to follow their polices

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074046	A. BUILDING: ______ B. WING ______	R-C 12/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA CARE ONE ASSISTED LIVING	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 273}	Continued From page 4	{D 273}		

and protocol related to changes in residents' condition.

Interview with the Administrator on 12/15/23 at 10:57am revealed:
-She expected the RCC or MA to notify the PCP of changes in resident's condition and document that in an incident report or in the residents' Care Notes.
-The facility did not notify Resident #4's PCP about the change in Resident #4's behaviors that occurred on 10/02/23, until the PCP was in the facility following day on 10/03/23 at approximately 11:00am.
-The facility was not able to locate any documentation showing the PCP or mental health provider were notified of the change in Resident #4's behaviors that occurred on 10/02/23.

____

The facility failed to notify the PCP for a resident (#4) who exhibited a change in behavior including agitation, reported feeling threatened by others and was in possession of a sharp metal object on 10/02/23 and was then involved in a physical altercation with another resident on 10/03/23, in which Resident #4 sustained a rib fracture. This was detrimental to the resident's welfare and constitutes an Unabated Type B Violation.

____

The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/15/23.